Empowered Wellness Counseling, LLC

Let's Walk It Out Medical Clearance

NAME _____
PHONE (own)_____
Emergency Contact and Phone # (identifying this person gives permission to contact in case of emergency situation)_____

I am very glad that you have decided to participate in the walk and talk available through Empowered Wellness Counseling, LLC. Whether it is a short walk from the office or counseling upon nature's trails at a local park, the benefits of exercise, nature and mental wellness make for a perfect combination. Prior to engaging in this type of support it is important to review a few items. Your well-being is of utmost importance to me. If you wouldn't mind answering the following questions before our first session I would appreciate it.

Has your doctor ever said you have a heart condition and that you should only do physical activity recommended by a doctor? ___Yes ____NO
Do you feel pain in your chest when you do physical activity? ___Yes ____NO
In the past month have you had chest pain when you were not doing physical activity? ___Yes ____NO
Do you lose your balance because of dizziness or do you ever lose consciousness? ___Yes ____NO
Do you have a bone or joint problem that could be made worse by a change in your physical activity? ___Yes ____NO
Is your doctor currently prescribing drugs (ie. Water pills) for your blood pressure or heart condition? ___Yes ____NO
Do you know of any other reason why you should not do physical activity? If yes, please explain.
_____
IF YOU ANSWERE YES TO ANY OF THE ABOVE QUESTIONS, you need to obtain your physician's written approval prior to "Let's Walk It Out."

Waiver of Liability: By signing this document, I acknowledge that I am in good health or have obtained my physician's written approval to participate in these sessions. I understand these sessions will not be strenuous, however are mild physical activity and I choose to participate completely voluntarily. I accept all responsibility for my health and any resultant injury or mishap that may affect my wellbeing or health in any way. I also know that I am responsible to bring any needed precautionary items with me such as an inhaler or epi pen, if these items are usual and prescribed. I also hold the responsibility to inform the therapist of any changes in my health or medical conditions that arise after the signing of this form. I hold harmless of any responsibility the therapist, facility or any person involved in this program.

Signature & Date _____